STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056190	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Ridge Post Acute LLC	525 South Central Avenue Glendale, CA 91204

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46779 Based on observation, interview and record review, the facility failed to provide adequate monitoring and supervision to ensure one of two sampled resident (Resident 1), who had severely impaired cognition and memory and was assessed at risk for elopement with diagnoses of dementia (a term used to describe a group of symptoms affecting memory, thinking and social abilities) did not elope from the facility on 11/14/2024. The deficient practice had resulted in Resident 1 eloping from the facility on 11/14/2024. As of 11/15/2024, Resident 1 had not been found by the facility staff. Resident 1 had the potential for fall and injury from being struck by motor vehicles. Resident 1 also had the potential to be exposed to extreme weather and malnutrition (lack of proper nutrition. Findings: During a review of Resident 1 ' s Admission Record indicated the facility admitted Resident 1 on 10/23/2024 with diagnoses that included dementia and heart failure (a condition that the heart isn ' t pumping as well as it should). During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 11/4/2024, indicated Resident 1 had severely impaired cognition (ability to think and reason) and memory. The MDS indicated Resident 1 required supervision or touching assistance for eating, chair/bed-to-chair transfer, walk 50 feet with two turns and walking 10 feet on uneven surfaces, and partial/moderate assistance with oral hygiene, toileting hygiene, shower/bathe self, and personal hygiene. The MDS also indicated Resident 1 had wander/elopement alarm. During a review of Resident 1 ' s Elopement Evaluation, dated 10/30/2024, indicated Resident 1 was at high risk for elopement. The Elopement Evaluation indicated Resident 1 had a history of elopement or attempted leaving the facility without informing staff; Resident 1 verbally expressed the desire to go home, packed belongings o go home or stayed near an exit door; Resident 1 wanders; Resident 1 ' s wandering behavior is a pattern, goal-directed with specific destination in mind; Resident 1 ' s wandering behavior likely to affect the safety or well-being of self/others; and Resident 1 has been recently admitted and is not accepting the situation. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056190	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Ridge Post Acute LLC	525 South Central Avenue Glendale, CA 91204

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Order Summary Report, dated 10/31/2024, indicated the physician order Resident 1 may have wander guard due to elopement risk score at six (high risk), starting on 10/30/2024. During a review of Resident 1 ' s Care Plan, dated 10/30/2024, the Care Plan indicated the goal was the resident will not leave facility unattended and the resident ' s safety will be maintained. The Care Plan indicated to identify if there is a certain time of day wandering/elopement attempts occur. During a review of Resident ' s with Wanderguard, dated 11/11/2024, indicated Resident 1 was on the list of Resident ' s with Wanderguard. During a review of the Facility ' s Elopement Binder, Resident 1 ' s picture and information were in the Elopement Binder. During an interview on 11/15/2024 at 11:52 AM, with the Licensed Vocational Nurse (LVN), the LVN stated Resident 1 always asked if he lived in the facility and he remembered the place where he used to live. The LVN stated Resident 1 was high risk for elopement and they put a wander guard on his wrist, and she checked his wander guard around 6:50 AM on 11/14/2024 which was working. The LVN stated the last time she saw Resident 1 was between 12 PM and 12:15 PM when she was passing medications to other residents. The LVN stated Resident 1 walked passing the medication cart and got some juice from her. The LVN stated it was between 12:50 PM and 1 PM, the Treatment Nurse (TXN) came to the nursing station and asking if someone saw Resident 1, then, everyone started to look for him and Code 10 (a code activated when a patient is missing) was called. During an interview on 11/15/2024 at 12:24 PM, with the Receptionist, the Receptionist stated his responsibility was stay at the front desk in the lobby to monitor the residents in the lobby. The Receptionist stated Resident 1 hangs out in the lobby and the activity room which the door was facing the lobby, and Resident 1 has said he wanted to leave the facility. The receptionist stated Resident 1 always held a plastic bag packed with his belongs and trying to go out. The Receptionist stated he reported Resident1 ' s behavior to the nurses, and they put a wander guard on his wrist. The Receptionist stated it was around 12:30 PM on 11/14/2024, he needed to use the restroom, then, he checked with an activity staff who was supervising the dining room during lunch time and the nursing supervisor at the nursing station who was assisting a resident, but they were busy at that time, so he decided to leave his post and go to the restroom without making sure someone was monitoring the lobby. The receptionist stated he saw Resident 1 sitting inside the activity room, holding his plastic bag, and looking outside before he left his post. The Receptionist stated he returned to his post 40 seconds later and the wander guard alarm by the lobby entrance was not beeping and he did not notice Resident 1 had eloped. The Receptionist stated he was unsure if Resident 1 was wearing the wander guard. The Receptionist stated the facility did not pre-assign other staff to cover his post when he was on break, and he could not find coverage for his break sometimes because everyone was busy with their own work. The Receptionist stated he should find someone to monitor the lobby before he left his post yesterday to prevent Resident 1 from leaving the facility without supervision. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056190	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Ridge Post Acute LLC	525 South Central Avenue Glendale, CA 91204

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 11/15/2024 at 1:45 PM, with the Administration (ADM), the facility ' s video footage of the surveillance camera at the lobby was reviewed. The ADM stated the Receptionist left his post and disappeared from the footage at 12:31:07 PM on 11/14/2024, shortly after, Resident 1, who was holding a plastic bag came out from the activity room, walked towards the entrance door, and left the facility at 12:31:23 PM on 11/14/2024 without staff ' s supervision. The ADM stated the Receptionist returned his post at 12:32:15 PM on 11/14/2024. The ADM stated there was no staff monitoring the lobby area during the time Resident 1 eloped and there should be a staff at the front desk to always monitor the lobby. During an interview on 11/15/2024 at 1:55 PM, with Resident 2, Resident 2 stated Resident 1 always said that he did not like here and he wanted to leave. Resident 2 stated he was looking for Resident 1 before lunch and he could not find him yesterday. During an interview on 11/15/2024 at 2 PM, with the Acting Director of Nursing (ADON), the ADON stated the Receptionist was supposed to find coverage before he left the post to ensure resident ' s safety and she did not why the Receptionist did not ask someone to cover him. During an interview on 11/15/2024 at 2:46 PM, with the Director of Nursing (DON), the DON stated Resident 1 ' s elopement on 11/14/2024 was because the Receptionist left his post without making sure someone was monitoring the lobby area. The DON stated the receptionist must find someone to cover the post and have staff available to help with coverage to ensure residents ' safety. The DON stated the facility did not provide adequate supervision to ensure Resident 1 ' s safety and Resident 1 was still not found at this time. During a follow up telephone interview on 11/26/2024 at 2:08 PM, with the ADM, the ADM stated the police informed him that Resident 1 was located and placed under police custody. The ADM stated the police informed him it was not clear if Resident 1 would return to the facility at this time. During a review of the facility ' s policy and procedure (P&P) titled, Receptionist, dated 10/2003, indicated the receptionist promotes a safe environment for residents, visitors, and staff at all times. During a review of the facility ' s P&P titled, Safety and Supervision of Residents, dated 7/2017, indicated Resident supervision is a core component of the systems approach to safety. During a review of the facility ' s P&P titled, Nursing-Wandering and Elopement, dated 6/2018, indicated the facility to enhance the safety of the residents, reinforce proper procedures for leaving the facility for residents assessed to be at risk for elopement, and provide extra monitoring on the residents ' whereabouts.